

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004972</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8111 S EMERSON AVE INDIANAPOLIS, IN 46237</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for 2 (two) State hospital complaint investigations.</p> <p>Complaint: #IN00090383 Unsubstantiated; lack of sufficient evidence.</p> <p>Complaint: #IN00097985 Unsubstantiated; lack of sufficient evidence.</p> <p>Facility: #004972</p> <p>Date: 4/10/2012 &amp; 4/13/2012</p> <p>Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor</p> <p>Franciscan St. Francis Health - Indianapolis is in compliance with 410 IAC 15-1.2-1, Compliance with rules and 410 IAC 15-1.5-6, Nursing services, Indiana State Hospital Licensure Rules.</p> <p>QA: cloughlin 04/30/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1